

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/18/2016
NAME OF PROVIDER OR SUPPLIER CROWN SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00190276.</p> <p>Complaint IN00190276 - Substantiated. No Deficiencies related to the allegations are cited.</p> <p>Survey date: February 18, 2016</p> <p>Facility number: 013328 Provider number: 013328 AIM number: N/A</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Sample: 03</p> <p>Crown Senior Living was found to be in compliance with 410 IAC 16.2 - 5 in regards to the Investigation of Complaint IN00190276.</p> <p>QR was completed by 99993 on 02/19/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE